Features

Chroniques

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Emphasis on MD–patient communication to start in medical school, UBC decides

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In brief

THE THEORY BEHIND A NEW PROGRAM at the University of British Columbia is that improved physician–patient communication will lead to better-informed patients, and the result will be better health outcomes.

En bref

LA THÉORIE QUI SOUS-TEND UN NOUVEAU PROGRAMME offert à l'Université de la Colombie-Britannique repose sur le concept selon lequel l'amélioration de la communication entre le médecin et le patient produira des patients mieux informés, ce qui améliorera les résultats sur la santé.

Eighty percent of patient complaints against British Columbia physicians arise because of communication problems, and Dr. Bill Godolphin thinks that number is way too high. The University of British Columbia professor, who heads an innovative new program called the Informed Shared Decision-Making Project (ISDM), says doctors often think they provide more information than they actually do, and patients often do not know the right questions to ask. Through the new project, he wants to develop a "higher range of communication skills" in doctors by teaching them how to assess a patient's willingness to take risks, evaluate treatment choices and work as a partner in making treatment decisions. The premise? Patients who are better informed have better health outcomes.

Dr. Rita Bakan, a psychologist who served as a public member of the College of Physicians and Surgeons of BC for 10 years and is now on the ISDM management committee, says that "over and over again what you hear is that communication is the major problem with medical skills." She says physicians have to be willing to acknowledge the need to improve these skills. In terms of medical students, she says, "there is very little indication [when first-year medical students are rated] of how good their communications skills are."

The project's first task was to develop a communications component for a new "Doctor, Patient and Society" course, which was implemented in the revamped UBC medical school curriculum in the fall of 1997. Because the teaching of advanced communication skills requires integration with clinical learning and knowledge about ethics, the ISDM material won't be included in the course until the current students' clinical years begin.

Godolphin, who is with the Department of Pathology, says there is no point in teaching students how to break bad news to patients while they are in their early, preclinical years. He also thinks that students' communication skills deteriorate while they are being trained, another reason for teaching the enhanced skills later in medical school.

Godolphin recruited a group of volunteer first-year medical students to discuss the previous communications course — a one-time experience in the first month of medical school — and offer suggestions for the new program. Vu Truong, one of the students, said that the ISDM-based curriculum would reflect a more realis-

tic view of "how medicine is viewed in society today" by producing doctors with "more awareness of what's going on around them."

The next stage involved defining "competencies" for communications skills in physicians and patients. Through a series of focus groups with patient organizations such as the Canadian Diabetes Association, "model" patients and patient educators helped develop the concepts behind ISDM. Five family physicians whose practices were considered models of good medical practice were also interviewed. The patients and physicians then experimented with role playing involving various clinical practice scenarios, with a goal of developing ideal relationships. These sessions were videotaped and used to refine the required competencies.

These first-year medical students participated in the initial stages of UBC's Informed Shared Decision-Making project

The physicians had a hard time articulating the skills that patients needed to play an active role in a patient–physician relationship. In contrast, patients, particularly those with long-term diabetes, appeared to have managed their relationships with their doctors successfully. These patients were often better informed than their physicians and assumed responsibility for the ultimate decisions concerning their condition. Patient educators were the most enthusiastic of the 3 groups, describing the ISDM concepts as "in tune with the times."

The list of 8 ISDM competencies that eventually emerged covers the process of developing an equal relationship with the patient, from establishing the patient's desire for information on disease management to assessing the impact of treatment choices. Of these, physicians had the most difficulty determining the patient's preference for information, negotiating treatment decisions and following up with the patient.

Some doctors felt other health professionals would be better at providing information and that patients may not be accustomed to being given choices. The doctors also said that they need time to develop relationships with patients, and that negotiation takes time. Dr. John Mail, who has been in family practice for 22 years, participated in an ISDM role-playing workshop. He says his patients usually want anecdotal, personalized information, and "you can give an evidence-based option while personalizing it."

The doctors also felt that negotiating treatment decisions and follow-up were difficult-to-acquire skills for which they lacked training. On the other hand, patients and educators felt that competence in this area was very important and they questioned physicians' commitment to negotiate in some situations — for example, when a doctor says he will not deal with a patient if the person refused to take a recommended drug. The patients and educators also stressed the need for clear action plans at the conclusion of a visit to a physician.

Most of the physicians involved indicated that the success of their efforts to apply the ideas about improving communication depended more on trial and error and talking to colleagues than on medical school training. Most of them made a greater effort with people aged under 50 and women, whom they perceived to be more receptive to a "partnership relationship."

A long list of suggestions for teaching informed shared decision-making, which was compiled by the participants, included adopting the strategies as a requirement for licensing and using them for peer reviews involving group practises. Godolphin says that some of the ideas are "quite interesting possibilities for innovation," and he plans to experiment further with them.

Carol Cole, a registered nurse who worked in a family practice for 6 years and participated in an ISDM workshop by playing the role of patient, believes that doctors would welcome the project's clearly defined communication strategies. However, she admits that the application is "far more difficult than I originally thought." Godolphin acknowledges that his behavioural approach to communication skills is not a "particularly easy sell."

"We are trying to make small steps toward the practice that in the ordinary medical office encounter [an estimated 80% of doctor–patient encounters], the patient will be involved in a decision that is based upon the best available evidence and the patient's preferences and circumstances." ?